

WISCONSIN MEDICAID REQUEST FOR NURSING HOME CARE DETERMINATION COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Completion of this form is required to initiate the determination of Medicaid reimbursement for nursing home care.

This is a mandatory form. Wisconsin Medicaid will not accept other versions of this form. Print or type the information on the form so that it is legible.

Providers may submit forms by fax to Wisconsin Medicaid at (608) 221-8815 or by mail to the following address:

Wisconsin Medicaid
Attn: Eligibility Unit
6406 Bridge Rd
Madison WI 53784

SECTION I — PROVIDER INFORMATION

Name — Billing Provider

Enter the billing provider's name.

Billing Provider's Medicaid Provider Number

Enter the eight-digit Medicaid provider number of the provider who will be submitting claims.

National Provider Identifier

Enter the national provider identifier, if available.

Address — Provider (Street, City, State, Zip Code)

Enter the address, including the street, city, state, and zip code of the billing provider.

Name — Nursing Home Contact Person

Enter the nursing home contact person's name for questions about this specific resident.

Telephone Number — Nursing Home Contact Person

Enter the telephone number, including the area code, of the nursing home contact person.

SECTION II — RECIPIENT INFORMATION

Name — Recipient (Last, First, Middle Initial)

Enter the recipient's last name, followed by his or her first name and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Recipient Medicaid Identification Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Address — Recipient (If Different from Provider Address — Include Street, City, State, and Zip Code)

Enter the complete address of the recipient's place of residence, including the street, city, state, and zip code if the billing provider's address is different from the recipient's current physical address.

Social Security Number — Recipient

Enter the recipient's nine-digit Social Security number. Do not enter any other numbers or letters.

Date of Birth — Recipient

Enter the recipient's date of birth in the MM/DD/YYYY format.

Gender — Recipient

Enter an "X" in the appropriate box to specify male or female.

Requested Payment Effective Date

Enter the requested payment effective date in the MM/DD/YYYY format.

Discharge Date

Enter the discharge or date of death in the MM/DD/YYYY format. For use only when a recipient is discharged from the facility.

Minimum Data Set (MDS) Submittal

Enter an "X" in the appropriate box. For cases where no minimum data set will be submitted, please submit the physician's orders and other appropriate information. This information will be used for nurse review in the care level determination process.

SECTION III — BUREAU OF QUALITY ASSURANCE INFORMATION

Self-Reported Level of Care for Staffing Purposes

Enter an "X" in the box next to the level of care you have established for the recipient for your staffing purposes. Completion of this information does not impact the Medicaid payment.